G. Subpart H--Substitution of Coverage

1. Basis, scope, and applicability (§457.800).

Title XXI requires that States ensure that coverage provided under SCHIP does not substitute for coverage under either private group health plans or Medicaid. Section 2102(b)(3)(C) of the Act requires that State plans include descriptions of procedures used to ensure that the insurance provided under the State child health plan does not substitute for coverage under group health plans. Another provision in title XXI relating to substitution of coverage is section 2105(c)(3)(B), which sets out the conditions for a waiver for the purchase of family coverage as described in §457.1010. Under this provision, States must establish that family coverage would not be provided if it would substitute for other health insurance provided to children.

In addition, title XXI contains several provisions aimed at preventing SCHIP from substituting for current Medicaid coverage. First, sections 2102(a)(2) and 2102(c)(2) of the Act requires States to describe procedures used to coordinate their SCHIP programs with other public and private programs. Second, section 2105(d) of the Act includes "maintenance of effort" provisions for Medicaid eligibility. That is, under section 2105(d) of the Act, a State that chooses to create a separate child health program cannot adopt income and resource methodologies for Medicaid children that are more restrictive than those in effect

on June 1, 1997. Furthermore, section 1905(u)(2)(b) of the Act also provides that a State that chooses to create a Medicaid expansion program is not eligible for enhanced matching for a separate coverage provided to children who would have been eligible for Medicaid in the State under the Medicaid standards in effect on March 31, 1997. Finally, section 2102(b)(3)(B) of the Act requires that any child who applies for a separate child health program must be screened for Medicaid eligibility and, if found eligible, enrolled in Medicaid.

This subpart interprets and implements section 2102(b)(3)(C) of the Act regarding substitution of coverage under group health plans and sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under premium assistance programs. These requirements apply only to separate child health programs.

Comment: Many commenters questioned the magnitude of the risk for substitution of private group health plan coverage by SCHIP coverage for children. Because the size of the risk of substitution by SCHIP coverage offered under both employer-sponsored insurance programs and non-employer-sponsored insurance programs is unclear, and because of the harm that substitution prevention policies may inflict, the commenters encouraged HCFA not to put forth a policy to prevent substitution that goes

beyond what is clearly required by the statute. Many commenters also recommended that we revisit our policy on substitution because of their concern that waiting periods and other substitution prevention policies are causing significant harm to families with children with special health care needs and argued that such families can ill afford to go without coverage for any period of time.

Response: We have revisited our policy on substitution and made several changes. With respect to substitution policies outside of the context of premium assistance programs, we note that the proposed regulatory text at §457.805 requires only that the State plan include reasonable procedures to prevent substitution. This approach permits State flexibility and implementation of policies based on the emerging research regarding substitution and on State experiences with substitution.

Our review of States' March 31, 2000 evaluations indicated that in those States with data on substitution of private coverage with SCHIP coverage, there was little evidence that substitution was as great an issue as initially anticipated.

Thus, we have revised the policy stated in the preamble to the NPRM regarding substitution procedures relating to SCHIP coverage provided outside of programs that offer premium assistance for coverage under group health plans as follows:

States that provide coverage to children in families with incomes at or below 200 percent of FPL must have procedures to monitor the extent of substitution of SCHIP coverage for existing private group health coverage, as was the policy for such coverage provided to families under 150 percent of FPL proposed in the preamble to the NPRM.

States that provide coverage to children in families with incomes over 200 percent of FPL should, at a minimum, have procedures to evaluate the incidence of substitution of SCHIP coverage for existing private group health coverage. In addition, States offering coverage to children in families over 200 percent of FPL must identify in their State plans specific strategies to limit substitution if monitoring efforts show unacceptable levels of substitution. States must determine a specific trigger point at which a substitution prevention mechanism would be instituted, as described in the State plan. For coverage above 250 percent of the FPL, because evidence shows that there is a greater likelihood of substitution at higher income levels, States must have substitution prevention strategies in place, in addition to monitoring.

Although a period of uninsurance is one possible substitution prevention procedure, we invite States to propose other effective strategies to limit substitution. States may submit amendments to their State plans if they would like to

modify their current policies in light of the policies discussed here. We plan to work closely with each State to develop appropriate substitution strategies, monitoring tools, and trigger mechanisms.

For premium assistance programs, we have revised our substitution policy in this final rule in two areas. We have eliminated the requirement for a 60 percent minimum employer contribution. We will no longer mandate a specific level of contribution, since a substantial employer contribution must be made in order for coverage subsidized through employer plans to be cost-effective, as required under section 457.810. States will be expected to identify a reasonable minimum employer contribution level and provide justification for that level, including data and other supporting evidence, that will be reviewed in the context of the State plan amendment process. In addition, as proposed in the NPRM, States with premium assistance programs must monitor employer contribution levels over time to determine whether substitution is occurring and report their findings in their State annual reports.

The identification of the minimum employer contribution and the monitoring process will help ensure that SCHIP funds are being used to supplement the cost of employer-sponsored insurance, not supplant the employers' share of the cost of coverage. While these revisions are intended to provide

additional State flexibility to develop premium assistance programs and provide coverage to families, it is important to note that the cost-effectiveness test established by title XXI and set forth in §457.810 must be met in all cases.

The second change we are making relates to the required waiting period of uninsurance. We have retained the requirement for a minimum 6-month period without group health coverage, but will permit exceptions to the waiting period, as discussed in more detail in the comments and responses to section §457.810.

2. State plan requirements: Private coverage substitution (§457.805).

The potential for substitution of SCHIP coverage for private group health plan coverage exists because SCHIP coverage may cost less or provide better coverage than coverage some individuals and employers purchase with their own funds. Specifically, employers who make contributions to coverage for dependents of lower-wage employees could potentially save money if they reduced or eliminated their contributions for such coverage and encouraged their employees to enroll their children in SCHIP. At the same time, families that make significant contributions towards dependent group health plan coverage could have an incentive to drop that coverage and enroll their children in SCHIP if the benefits would be comparable, or better, and their out-of-pocket costs would be reduced.

In accordance with section 2102(b)(3)(C) of the Act, we proposed at §457.805 to require that each State plan include a description of reasonable procedures that the State will use to ensure that coverage under the State plan does not substitute for coverage under group health plans.

We opted not to propose specific procedures to limit substitution. Instead, we discussed in detail reasonable procedures that States may use to prevent substitution of coverage. Specifically, we stated in the preamble to the NPRM that we would consider the following to be reasonable procedures for addressing the potential for substitution:

- States that provide coverage to children in families at or below 150 percent of the Federal poverty line (FPL) should, at a minimum, have procedures to monitor the extent of substitution of that coverage for existing private group health coverage.
- States that provide coverage to children in families between 150 and 200 percent of FPL should, at a minimum, have procedures to study the incidence of substitution of that coverage for existing private group health coverage. In addition, States should specify in their State plans the steps they will take to prevent substitution in the event that the States' monitoring efforts discover substitution has occurred at an unacceptable level.
- States that provide coverage to children in families above

200% of FPL should implement, concurrent with program implementation, specific procedures or a strategy to limit substitution.

We noted that we would ask States to assess the procedures to limit substitution in their evaluations submitted in March of 2000. We also asked all States that specified in their plans that they would monitor substitution to submit information on substitution in their annual reports.

We also addressed the issue of applying substitution provisions to the Medicaid eligibility group for the "optional targeted low-income children", which was added to section 1902(a)(10)(A)(ii)(XIV) of the Act pursuant to section 4911 of the BBA. In the NPRM we clarified that States may not apply eligibility-related substitution provisions, such as periods of uninsurance, to the "optional targeted low-income children" group, because such eligibility conditions are inconsistent with the entitlement nature of Medicaid. We have retained this policy in this final regulation. States that currently apply eligibility-related substitution provisions to optional targeted low-income children will need to come into compliance with this clarified policy. States that have not already come into conformity with this policy will have 90 days from the date of this notice to do so and must submit a State plan amendment in compliance with §457.65(a)(2). We recognize that States

expanding Medicaid to optional targeted low-income children at higher income levels may be particularly concerned about the potential for substitution of coverage. States that want to maintain waiting periods for the optional targeted low-income children group may want to submit section 1115 demonstration requests for approval of substitution provisions. HCFA will consider section 1115 demonstration requests on a case-by-case basis.

Comment: Although neither the preamble nor the proposed regulatory text explicitly prescribed a mandatory waiting period or period without group health insurance, as a condition of eligibility in separate child health programs that are not providing premium assistance for group health plans, many commenters expressed their dislike for the Department's policy implemented in the course of approving State plans and plan amendments, of mandating the imposition of periods without insurance for populations over 200 percent of the FPL.

Many commenters indicated that waiting periods are unnecessary in general because they block access to care without any proof of their effectiveness in preventing substitution. Some commenters stated that the data on the significance of substitution has been inconclusive. One commenter referred to recent data from the Current Population Survey (CPS) on trends in coverage for low-income children that, in their view, raised

serious questions about the magnitude of any crowd out effect of expansions in publicly-funded coverage for children. Another concern raised was that waiting periods without insurance impose a significant hardship for families who may be struggling to keep up premium payments, obtain care for children with special health care needs, or get by with inadequate private coverage for their children.

Response: Our review of States' March 31, 2000 evaluations indicated that in those States with data on substitution of private coverage with SCHIP coverage, there was little evidence that substitution was as great an issue as initially anticipated. However, because of the current lack of conclusive data around the level of substitution which may be occurring below 200 percent of FPL, we maintain that monitoring of substitution of coverage in SCHIP is critical.

As noted above, we have revised the policy stated in the preamble to the NPRM regarding substitution procedures relating to SCHIP coverage provided outside of programs that offer premium assistance for coverage under group health plans as follows:

! States that provide coverage to children in families at or below 200 percent of FPL must have procedures to monitor the extent of substitution of SCHIP coverage for existing private group health coverage, as was the policy for such coverage provided to families under 150 percent of FPL proposed in the

preamble to the NPRM.

! At a minimum, States that provide coverage to children in families with incomes over 200 percent of FPL should have procedures to evaluate the incidence of substitution of SCHIP coverage for existing private group health coverage. In addition, States offering coverage to children in families over 200 percent of FPL must identify in their State plans specific strategies to limit substitution if monitoring efforts show unacceptable levels of substitution. States must monitor the occurrence of substitution and determine a specific trigger point at which a substitution prevention mechanism would be instituted, as described in the State plan.

! For coverage above 250 percent of the FPL, because evidence shows that there is a greater likelihood of substitution at higher income levels, States must have substitution prevention strategies in place, in addition to monitoring.

Although a period of uninsurance is one possible substitution prevention procedure, we invite States to propose other effective strategies to limit substitution. States may submit amendments to their State plans if they would like to modify their current policies in light of the policies discussed here. We plan to work closely with States to develop appropriate substitution strategies, monitoring tools, and trigger mechanisms. As part of monitoring for substitution of coverage,

States should also study the extent to which anti-substitution policies require children who have lost group health coverage through no fault of their own or their employer to wait to be enrolled in SCHIP. To the extent that monitoring finds that such children are forced to go without coverage, States should consider adjustments to their substitution prevention policies that permit exceptions for children who should not be the target of such policies. We will continue to ask States to assess their substitution prevention procedures in their annual reports.

Finally, we note that because the regulatory text at §457.805 required that the State plan include reasonable procedures to prevent substitution and made no distinction for eligibility levels for coverage under State plans, we have not revised the regulation text. It is consistent with our revised policy.

Comment: Several commenters believed that States should be allowed to establish guidelines that would allow families to drop coverage without penalty of a SCHIP-required waiting period and to enroll the child or children in the State's SCHIP program if they are paying more than they can afford for the child's insurance. The commenters indicated that, in some cases, the child may have special health needs and/or the family may be paying for insurance that does not cover many of the child's needs but serves only as insurance against a catastrophic event.

In addition, some commenters suggested that States not be allowed to impose periods of uninsurance that impede the delivery of preventive care and immunizations consistent with the *AAP Guidelines for Health Supervision III and Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*.

Response: As stated above, periods of uninsurance will not be required unless coverage is provided via premium assistance through group health plans, coverage is provided to children with significantly higher income levels, or substitution has been identified as a problem in the State. Furthermore, in the case of States with premium assistance programs, we continue to permit States to cover such children under a separate child health program (outside of coverage through premium assistance programs) during the waiting period, as stated in the preamble to the proposed rule. The required period of uninsurance applies only to SCHIP coverage provided through group health plans.

States are therefore able to enroll special needs children, and those in need of preventive care and immunizations, in SCHIP in a timely fashion so as not to disrupt the provision of needed health care services. To the extent a State chooses to adopt periods of uninsurance, the State may want to consider exceptions to the period of uninsurance to address issues raised by the commenters. We note, however, that access to immunizations is

unlikely to be proposed as an exception since virtually all younger children would thereby be exempt.

Comment: One commenter urged the Department to view State substitution prevention efforts as a comprehensive plan, rather than isolating specific pieces that may or may not measure up to artificial Federal guidelines. In addition, the commenter noted that each State has developed a substitution prevention strategy that is applicable to the demographic and economic situation in the State, and State plans should therefore be judged in their entirety, not in a piecemeal fashion.

Response: We agree that State's substitution prevention efforts should be considered in the context of the entire State plan with consideration given to a State's particular needs and goals. To this end, we have retained a flexible regulatory requirement regarding substitution and indicated that HCFA will incorporate additional flexibility in its plan review process.

Comment: One commenter agreed with the language in proposed §457.805 and suggests that HCFA limit States' discretion to use fears about substitution as an excuse to deny health coverage and recommended that final regulations bar waiting periods (outside of the premium assistance arena) that either: (1) impose harm on children by going beyond 6 months or deny coverage (except where the employee voluntarily drops employment-based coverage without any change in circumstances) for pregnant women, children with

disabilities, or children with preexisting conditions as defined by HIPAA; or (2) deny SCHIP benefits to children without employer-sponsored insurance for reasons unrelated to SCHIP (recent adoption, loss of job, end of COBRA coverage, death of a parent, moving outside the plan's service area, or an increase in premiums that was unaffordable to the family).

Response: As indicated above, outside of premium assistance programs, States have broad discretion to develop substitution prevention policies that best serve their particular populations. States that choose to retain or impose periods of uninsurance are encouraged to include exceptions that help prevent the imposition of undue hardship under a range of circumstances, including loss of insurance through no fault of the family, extreme economic hardship, death of a parent, etc.

Comment: One commenter indicated that, while in agreement that our proposed policy on substitution for the lower income population is reasonable, HCFA should carefully monitor State programs for children under 200% FPL to assure that no substitution problems emerge.

Response: We will continue to review State plan amendments to ensure that States monitor the occurrence of substitution at all income levels, and to review annual reports for any reported experiences of substitution. As stated in previous guidance from HCFA, in the event monitoring efforts indicate unacceptable

levels of substitution, HCFA may reconsider the requirements intended to prevent substitution of coverage.

Comment: One commenter indicated confusion about the preamble language which "does not require" the use of eligibility-related substitution prevention provisions such as periods of uninsurance for the Medicaid eligibility group for the "optional targeted low income children," but goes on to say that States that currently apply eligibility-related substitution prevention provisions to optional targeted low-income children "will need to come into compliance with this proposed policy." The commenter believed our language should have indicated we would "not allow" such States to impose a waiting period as opposed to "not require."

Response: The commenter is correct. The policy is that the Medicaid statute does not allow the use of eligibility-related substitution prevention provisions such as periods without insurance for "optional targeted low income children" (outside of demonstration projects under the authority of section 1115 of the Act).

Comment: One commenter asked for clarification whether the proposed requirements with respect to substitution at §457.800(c) applied only to separate child health programs and not to Medicaid expansion programs.

Response: As noted by the commenter, this point needs

clarification. This subpart, as stated at §457.800(c), applies only to separate child health programs. We have removed the reference to subpart H at §457.70, which had indicated the requirements that apply to Medicaid expansion programs.

Comment: Several commenters indicated support for the clarification that waiting periods are not allowed in Medicaid expansions (outside of section 1115 demonstrations). One commenter asserted that this is consistent with Congressional intent that all Medicaid rules should apply to title XXI expansions of Medicaid. Another commenter suggested using caution when granting 1115 demonstrations to implement substitution prevention provisions when expanding Medicaid eligibility.

Response: We agree with the first two points and note the concerns raised in connection with section 1115 demonstrations.

Comment: One commenter indicated that States should be permitted the flexibility to implement the substitution provisions that they determine are necessary for their own SCHIP programs, and that this should be the rule whether the program is a Medicaid expansion or a separate program. Another commenter believed that it is unfair not to require a six-month waiting period for Medicaid expansion programs because it presents an unfair barrier to separate child health programs.

Response: The final rule allows States the flexibility to

identify and implement substitution prevention provisions that are necessary for their own separate child health programs, within the parameters discussed above. Title XXI explicitly requires States to have substitution policies. By contrast, waiting periods are not permitted in Medicaid expansion programs outside of section 1115 demonstrations.

Comment: One commenter stated that HCFA should consider whether the imposition of substitution provisions, such as mandated periods of uninsurance applied to adults under family coverage waivers, would have an undesirable effect on the children's access to services.

Response: We agree that waiting periods may have an adverse impact on children's access to care. In this final rule, HCFA is requiring States to monitor the extent to which substitution prevention policies require children who have lost group health coverage, through no fault of their own or on the part of their employer, to wait to be enrolled in SCHIP. If monitoring shows that such children are forced to go without coverage, States should consider adjustments to their substitution prevention policies that permit exceptions for children who should not be the target of such policies. Because research shows that the risk of substitution is greater when a State operates a premium assistance programs, we will continue to require that such coverage be available after a six month period of uninsurance.

However, this policy does not prevent States from covering SCHIP enrollees, whether children or families, through a separate child health program or through Medicaid. The final rule also permits States to adopt reasonable exceptions to the waiting period requirement. (See the discussion of the comments and responses on §457.810.) Thus, the premium assistance substitution policy does not require that children be uninsured prior to enrolling in a premium assistance program.

Comment: One commenter believed that collaboration with the Child Support Enforcement Program is necessary and that any efforts to monitor potential substitution of private employer group coverage should include a review for coverage which may already be provided by a noncustodial parent, or which may potentially be available through a noncustodial parent pursuant to a support order. The commenter also asked that the definition of substitution be clarified and recommended a definition of "equivalent to SCHIP coverage" or some State-defined minimum requirements. The commenter appeared to believe that coverage inferior to SCHIP coverage carried by a noncustodial parent should not be considered health insurance coverage when determining whether SCHIP coverage is substituting for private group health insurance coverage.

Response: We agree that a State's SCHIP program should coordinate with the State's Child Support Program and that

coverage under, or available through, a noncustodial parent's health plan should be considered by the State with respect to its substitution policies. The commenter is concerned that coverage available from the noncustodial parent be equal to SCHIP coverage or some State-defined minimum coverage before a concern for substitution should arise. We note that this final rule does not require that children be denied SCHIP coverage if the noncustodial parent has insurance that could cover the child. CSE agencies should be informed about the availability of SCHIP coverage because, as the commenter suggests, SCHIP coverage might provider better access to care than coverage potentially available through the noncustodial parent. The statutory provisions do, however, preclude SCHIP eligibility for a child who already has coverage under a group health plan or health insurance coverage, as those terms are defined under HIPAA. The only exceptions to this policy are if the child does not have "reasonable geographic access" to coverage, as described in subpart C, or if the policy meets the definition of "excepted benefits" under HIPAA.

3. Premium assistance programs: Required protections against substitution (§457.810).

We proposed under §457.810 to require any State that implements a separate child health program under which the State provides premium assistance for group health plan coverage, to

adopt specific protections against substitution. A State must describe these protections in the State plan. In the NPRM, we proposed that the following four requirements would need to be met to protect against substitution:

! Minimum period without group health plan coverage. The child must not have been covered by a group health plan during a period of at least six months prior to application for SCHIP. States may require a child to have been without such insurance for a longer period, but that period may not exceed 12 months. States may permit exceptions to the minimum period without insurance if the prior coverage was involuntarily terminated. We noted that newborns who are not covered by dependent coverage would not be subject to a waiting period. We also noted that the waiting period applies only to coverage through a group health plan, not SCHIP or Medicaid coverage. If an otherwise eligible child does not meet the requirement for a minimum period without group health plan coverage, the State can enroll the child in SCHIP under a separate child health program without purchasing employer-sponsored coverage for the interim waiting period, and can still consider the child uninsured for purposes of the waiting period. That is, coverage under a separate child health program or Medicaid does not count as group health insurance coverage for purposes of the required waiting period prior to enrollment in SCHIP coverage provided via premium assistance

programs.

! Employer contribution. The employer must make a substantial contribution to the cost of family coverage, equal to 60 percent of the total cost of family coverage. States proposing a minimum employer contribution rate below this standard must provide the Department with data that demonstrate a lower average employer contribution in their State and support a State's contention that the lower contribution level will be equally effective in ensuring maintenance of statewide levels of employer contribution. In addition, the employee must apply for the full premium contribution available from the employer.

! Cost-effectiveness. The State's payment under its premium assistance program must not be greater than the payment that the State otherwise would make on the child's behalf for other coverage under the State's SCHIP program.

! State evaluation. The State must collect information and evaluate the amount of substitution that occurs as a result of payments for group health plan coverage and the effect of those payments on access to coverage. To conduct this evaluation, States must assess the prior insurance coverage of enrolled children. States may obtain information on prior coverage through the enrollment process, separate studies of SCHIP enrollees, or other means for reliably gathering information about prior health insurance status. In the preamble to the

NPRM, we set forth specific examples of questions States could include in SCHIP applications to evaluate the prevalence of substitution. We noted that we would reevaluate our position on the requirements for States that subsidize employer-sponsored plans based on our review of the State evaluations due March 31, 2000.

Comment: One commenter noted that employer ignorance of changing public benefit rules is one of the most effective safeguards against widespread substitution, and things such as competitive market pressures and rising health costs, not changing Medicaid and SCHIP coverage rules, drive reductions in employer subsidies for health coverage. Further, the commenter stated that the safeguard of employer ignorance ends when the employer is contacted by a State agency and becomes a partner in purchasing SCHIP coverage. Another commenter indicated their belief that HCFA is inconsistent by indicating that it will scrutinize SCHIP programs subsidizing employer-sponsored insurance while suggesting (in §457.90) that "Employer-based outreach is another avenue for providing...information on children's insurance programs."

Response: We note these comments and have sought to craft a substitution prevention policy that reflects the different pressures on the employer market and that balances States' desire for developing premium assistance programs with the risk that

such programs will not expand coverage for children, but merely substitute employer contributions with SCHIP funds. There are both benefits and risks of partnering with employers in designing premium assistance programs. We have provided new flexibility to States to design such programs under these final rules, while retaining some requirements that are critical for preventing substitution.

Comment: Many commenters indicated their strong disagreement with the mandatory six-month minimum period without group health insurance coverage prior to application for SCHIP premium assistance coverage through group health plans. Their arguments against this policy included that it has no basis in statute, that it is inconsistent with other SCHIP strategies to prevent substitution which allow State flexibility, and that waiting periods block access to coverage and care for an arbitrary period without evidence of the effectiveness of any particular length of waiting period in preventing substitution. Some of these commenters added that if HCFA maintains a requirement for a period without employer-sponsored insurance prior to eligibility for SCHIP coverage obtained through premium assistance programs, that the minimum period be changed to 3 months. One commenter noted that there is no State system in place to confirm if and when an individual was previously covered under group health plans and that requiring States to establish

such a system would be onerous and administratively costly.

Response: We have revisited and made revisions to our policy on substitution generally, and our policy on required periods of uninsurance, with respect to premium assistance for coverage under group health plans.

As discussed above, when a State operates premium assistance for group health insurance coverage, the State is no longer required to comply with the requirement that the employer contribution be at least 60 percent of the premium cost. The other requirements described in the proposed rule would continue to apply; namely, the requirements that the employee eligible for the coverage apply for the full premium contribution available from the employer, that such coverage be cost-effective, and that the State evaluate the amount of substitution that occurs as a result of payments for group health insurance coverage and the effect of those payments on access to coverage.

In addition, because of the greater likelihood of substitution of SCHIP coverage for group health insurance coverage offered by employers, we are retaining the requirement for a 6-month waiting period, but allowing States greater flexibility to vary from this general requirement. The default substitution prevention mechanism will be a period of uninsurance of at least six months, and not more than 12 months, without group health insurance prior to eligibility for SCHIP premium

assistance for coverage through group health insurance plans offered by employers. States may also develop reasonable exceptions to the required waiting period when they can identify limited circumstances in which substitution is less likely to occur. For example, if a State is targeting its premium assistance program to certain employers that provide only very limited health insurance coverage, a waiting period may not necessarily be required since the likelihood of substitution would be limited in those circumstances.

In proposing exceptions to the six-month waiting period, States must provide reasonable justification for such exceptions, including data and other supporting evidence, as appropriate, which will be reviewed by HCFA in the context of the State plan amendment process. We have also listed several specific exceptions to the waiting period that may be granted, including involuntary loss of coverage due to employer termination of coverage for all employees and dependents, economic hardship, and change to employment that does not offer dependent coverage. And, as noted above, States also must monitor their premium assistance programs to determine whether substitution may be occurring. We plan to work closely with States interested in providing coverage via premium assistance for group health insurance coverage in order to provide technical assistance and help achieve a balanced approach that allows premium assistance

plans to be implemented with appropriate safeguards to prevent substitution.

Comment: Many commenters expressed concern about the 60 percent employer contribution requirement at proposed §457.810(b)(2) for SCHIP coverage provided through employer-sponsored insurance because employer contributions may vary in a State based on region, type and size of business, and wage levels of employees. The commenters' expressed the position that HCFA has exceeded its statutory authority in setting this benchmark, and they argued that it is unnecessary. Furthermore, the commenters stated that few employers contributing less than 60 percent of the premium would meet the required cost effectiveness test. The commenters noted that the statutory requirement that the purchase of employer-sponsored insurance with SCHIP funds must be cost effective is the most appropriate tool to use. One commenter indicated that the employer contribution standard should not be based on a statewide average of all businesses, but should be appropriate to, and specific to, those businesses which would participate in the SCHIP program that would utilize an existing health purchasing cooperative consisting of small businesses. One commenter also indicated that the level of substitution is unlikely to be affected by the 60 percent requirement, because employers would probably not base their health coverage decisions on the needs of employees eligible for

premium assistance who, for many companies, represent only a small fraction of their overall employee pool. The commenter stated that crowd out occurs because of individual rather than corporate decisions, such as when individual employees elect to drop private coverage for low-cost or no-cost public assistance. Finally, the 60 percent would be problematic for some commenters' States because those States are operating under approved 1115 demonstrations to allow premium assistance when employers contribute at least half the cost of coverage.

Another commenter cited a survey that showed that in regions other than on the east coast, very few employers pay any part of the dependent premium. The recent survey indicated on average, large employers pay 85.51% of the employee premium and 17.62% of the dependent premium, and that small employers contribute 78.06% of the employee premium and 5.14% of the dependent premium. According to this commenter, HCFA's requirement actually prevents access for many children.

Several commenters that disagreed with the 60 percent employer contribution requirement suggested it be deleted in favor of maintaining a cost-effectiveness test while requiring States to simply describe how they plan to monitor employer contribution percentages to detect any reductions in the contributions and assess whether reductions may be related to SCHIP premium assistance. Other commenters also recommended

subjecting employers to a maintenance of effort requirement with respect to the contribution level.

One commenter recommended that if a minimum requirement is maintained, States be permitted to establish different standards for different kinds of employers, including making distinctions based on whether or not the employer has previously offered health insurance coverage and on the wage distribution of the employer's work force.

It was one commenter's opinion that failure to allow State flexibility on the employer contribution will stifle many potential innovative approaches to reach uninsured children of low-wage workers and that States will be unable to enroll sufficient numbers of children in these programs to justify the administrative expense. In addition, in this commenter's view, the 60 percent requirement may result in many families who would prefer premium assistance being forced to enroll their children in the regular SCHIP program, and force the State to forego any employer contribution. The commenter also noted that, if more low-wage workers decline dependent coverage when it is offered, employers with many low-wage workers may stop offering coverage, causing a long-term, population-wide shift from private to public sources of coverage.

Another commenter stated that the small employers in its State do not pay 60 percent of family health coverage premiums

and, in fact, most do not cover dependents. The commenter believed that they should be allowed to include in premium assistance programs employers who are currently not covering dependents. They suggested a rule that would only include employers who did not cover dependents as of a certain date, or who paid less than a predetermined amount for coverage as of that date. The State would then use local objective data (and not "outdated, national surveys of large employers") to determine the contribution amount appropriate for the locality. One commenter indicated that our proposed policy would punish families who find jobs with employers who contribute less than 60 percent and encourage them to take jobs with employers that don't offer family coverage.

A commenter also suggested that whatever standard is adopted, there should be exceptions in instances in which employer contribution percentages drop solely because of an increase in premiums or where an employer drops its level of contribution because of documented and significant economic declines. In such cases, the commenter argued, crowd out isn't a factor in the reduced employer contribution level, and failure to allow employers in such circumstances to reduce their contribution levels may result in employees and their families losing their insurance. One commenter said, regarding the 60 percent employer contribution, that HCFA should not presume the

cost neutrality of State initiatives to link title XIX/XXI coverage to low-wage workers, and said that the proposed regulations indirectly restrict a State's discretion to define eligibility and thereby exceed Congressional intent. Moreover, in this commenter's view, by establishing such a high level of employer contribution, HCFA effectively is excluding dependents of small business employees from participating in SCHIP.

Another commenter stated that a required percentage of employer contribution for participation in SCHIP premium assistance programs would give employers a target that could be misused. If an employer arbitrarily reduced its percentage of contribution, the employer could eliminate the opportunity for additional SCHIP-eligible employees to purchase employer health insurance with the help of premium assistance. In the commenter's State, only 2.5 percent of eligible individuals with access to employer-sponsored health coverage have access to family coverage where the employer pays 60 percent or more of the premiums. For nearly 30 percent of the State's eligibles with access to family coverage via an employer, the employer contributes about 10 percent less than the 60 percent minimum. In this commenter's view, our proposed rule would eliminate the opportunity for these individuals to be covered under a premium assistance program.

One commenter expressed disappointment that HCFA did not

deviate from the policy expressed in the February 13, 1998 letter and indicated that the guidance is overly prescriptive and biased against the development of State approaches to SCHIP using employer-sponsored coverage. The commenter suggested providing additional State flexibility in determining the amount of employer contribution as long as plans certify that issues related to crowd out and substitution are addressed. If, upon evaluation, State efforts do not result in permissibly low levels of substitution, the commenter stated they would be happy to assist in the development of more detailed and specific guidelines. If the 60 percent requirement is not eliminated, this commenter suggested that States should be allowed to develop an alternative State average based on size of business, number of employees, number of low-wage employees or some other relevant factor.

Another commenter stated that there is no evidence in its Health Insurance Premium Program (HIPP) that employers have reduced their contribution because HIPP is paying the premium, and the commenter would not expect employers to act differently with respect to SCHIP. The commenter indicated that employers have other employees to consider and there is no evidence to support the position that employers will reduce their contribution because some employees are subsidized. They stated their belief that the majority of employers recognize the value

of providing health care coverage to their employees and want them insured.

In this commenter's view, HCFA's position penalizes employees of employers who are not financially able or willing to contribute more, especially when health plans impose large premium increases. Also, the commenter believed that HCFA's position penalizes States by limiting their ability to buy-in to cost effective employer coverage and increasing the administrative burden for States. The commenter recommended that, if the employer plan is cost effective, States should have the flexibility to take advantage of the coverage, regardless of the amount of employer contribution.

Response: We appreciate the concerns raised by these commenters and we have revised our policy in this final rule to provide additional flexibility for States wishing to utilize premium assistance programs. We will no longer require States to implement a minimum employer contribution of 60 percent. We agree with the commenters' position that the cost-effectiveness requirement of the statute reduces the need for a uniform minimum employer contribution level, because it is likely that a substantial employer contribution would be necessary in order to meet the test of cost-effectiveness. However, States must identify a specific minimum employer contribution level to ensure that SCHIP funds are used to supplement the cost of employer-

sponsored insurance rather than supplant the employers' share of the cost of coverage, and we have maintained the requirement that States evaluate substitution in the context of their premium assistance program in their annual reports. While allowing for significant new flexibility, this policy also encourages States to require the highest possible employer contribution level that is reasonable given the circumstances in their State. In addition, the rules maintain the requirement that the employee eligible for the coverage must utilize the full premium contribution available from the employer.

We recognize that it may be necessary to revisit this policy as States gain experience with the provision of SCHIP coverage and we receive further evaluations of substitution with respect to SCHIP coverage provided through premium assistance for employer-sponsored insurance. The requirements set forth in this final rule represent our position on the steps necessary to implement the statutory provisions of section 2102(b)(3)(c) of the Act in light of what is now known about the interaction between private and public coverage. The rules provide considerable flexibility, allowing States and HCFA room to adjust the approach to substituion based on experience with the program.

Comment: One commenter agreed with the proposed rule's flexibility to allow less than 60 percent employer contribution to family coverage if the State average is less than 60 percent.

Response: We appreciate the support and as stated above, we have dropped the 60 percent contribution requirement in part because we recognize the variation in levels of average employer contributions across States.

Comment: One commenter strongly disagreed with our proposal to allow States to set a lower standard for employer contributions than 60 percent. The commenter asserts that because of the lack of data on "average" employer contributions to dependent coverage, especially with regard to small employers, and the fact that the average contribution among employers with 50 or fewer employees is zero percent, and in the commenter's State large employers also often contribute nothing, the commenter believes our proposed policy of allowing a less than 60 percent contribution would permit the allowance of premium assistance programs even where the employer contributes nothing at all.

Response: A contribution level of less than 60 percent is permitted under these final rules, as long as the cost-effectiveness test is met. We do not agree that premium assistance programs likely would be allowed when there is no employer contribution, as the commenter suggested, because the cost-effectiveness test is unlikely to be met without a substantial employer contribution.

Comment: One commenter suggested that HCFA clarify whether

(and how) the NPRM's preamble discussion of determining cost-effectiveness under family coverage waivers applies with respect to using employer-sponsored insurance to provide coverage under SCHIP.

Response: The cost-effectiveness requirement in §457.810(c) applies when a State provides premium assistance programs for SCHIP eligible children. The cost-effectiveness test for premium assistance for group health insurance coverage requires a comparison of the cost of coverage of the child that would otherwise be available under SCHIP to the State's cost to provide premium assistance for group health insurance coverage for that child. We have modeled the discussion of the cost-effectiveness test in the regulation text after the provision related to States that wish to cover family members, in addition to targeted low-income children at §457.1015. We have specified that the State's cost for coverage for children under premium assistance programs must not be greater than the cost of other SCHIP coverage for these children. Consistent with cost-effectiveness test for family coverage, the State may base its demonstration of cost-effectiveness on an assessment of the cost of coverage for children under premium assistance programs to the cost of other SCHIP coverage for these children, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

See the discussion at §457.1015 for further details on cost-

effectiveness for family coverage waivers.

Comment: One commenter indicated that the 60 percent requirement would unrealistically require a large base of employers to report data on contribution levels to the State in order for the State to satisfy the contribution requirement. Other commenters suggested we require States to evaluate the percent of income families would have had to spend to maintain employment-based or individual coverage during the period they waited for SCHIP coverage in assessing their substitution prevention procedures for their March 2000 evaluations and annual reports. They recommended that State evaluations and annual reports assess whether individual employers are terminating coverage for low-wage workers while maintaining coverage of higher wage workers and executives. Such an assessment should also examine increases in the amounts that employers are asking low-wage workers to contribute toward employment-based insurance coverage. Another commenter noted that few States will have implemented the employer buy-in option by the time of the March 2000 evaluations for HCFA to establish policy based on those evaluations.

Response: We are no longer imposing a minimum employer contribution requirement and recognize that there is not much experience to-date with premium assistance programs. As HCFA and the States gain experience, we will be in a better position to

evaluate the extent of substitution taking place. We recognize that there is limited data regarding employer coverage and contributions based on wage-levels of employees as well as State based information on the percent of income families would have had to spend to maintain private coverage while waiting for SCHIP coverage. In addition, we note that market forces other than SCHIP may influence the level of employer contribution and further complicate such analyses. We encourage States to assess these issues but recognize that data to support such assessments may be difficult to obtain and therefore do not require it.

Comment: Several commenters noted concern about HCFA's policy permitting States to provide direct SCHIP coverage to children during the six-month waiting period via the State's separate child health program (other than premium assistance programs). Commenters indicated that this policy itself would actually facilitate crowd out as families dropped their privately-funded coverage in favor of publicly-funded benefits and that the privately-funded coverage would not resume until six months of publicly-funded coverage passed. In addition, one commenter noted that coverage under the State's regular SCHIP program is less cost-effective than its coverage under a premium assistance program.

Response: To the extent that the part of State's separate child health program that does not involve premium assistance

requires either no period of uninsurance or a shorter one, there would be nothing to prohibit a child from being enrolled in that portion of the program even if the family had recently dropped coverage under its group health plan. There is no reason that States should not be allowed to offer such coverage, although we believe it is unlikely that many families will drop their private group health insurance for coverage under a State's separate child health program, in part because most families would prefer to keep coverage of all the family members under one plan.

Comment: Many commenters suggested inclusion in the regulation of a mandatory list of exceptions to the proposed minimum 6-month waiting period and also encouraged the Department to prohibit waiting periods in excess of six months. Suggested exceptions included when: 1) an eligible individual is pregnant or disabled; 2) a waiting period exceeds the 63-day gap limit under HIPAA and would result in exclusion of coverage for a preexisting condition under the coverage offered by the State's separate child health program; 3) an eligible child is a newborn or recently adopted; 4) the waiting period would block coverage of a well-baby, well-child, or immunization service according to the periodicity schedules for such services; 5) insurance is lost because of involuntary job loss; 6) insurance is lost because of death of a parent; 7) insurance is lost because of a job change to employment where the new employer does not cover dependents;

8) a family moves out of the service area of employer coverage; 9) an employer terminates insurance coverage for all of its employees; 10) COBRA insurance benefits expire; 11) employment-based insurance ends because an employee becomes self-employed; 12) insurance is lost because of long-term disability; 13) insurance is terminated due to extreme economic hardship of the employer or employee; and 14) there is a substantial reduction in lifetime medical benefits or benefit category to an employee and dependents in an employee-sponsored plan. One of the commenters also suggested an exception when there has been a loss or termination of employer-based coverage due to affordability problems that would be determined based on a percentage of income. In addition, some commenters suggested exceptions when an eligible child has insurance that only provides limited coverage such as catastrophic coverage, hospital-only coverage, or scholastic coverage with very high deductibles, because these policies wouldn’t allow access to preventive medical benefits.

Response: HCFA encourages States that impose waiting periods without group health coverage to consider adopting exceptions. Many States have adopted exceptions to the period of uninsurance based on a variety of factors. We have approved exceptions for reasons such as: loss of insurance due to involuntary job loss, death of a parent, change of employment where the new employer does not cover dependents; a family moved

out of the service area of employer coverage; employer termination of insurance coverage for all employees; expiration of COBRA insurance benefits; end of employment-based insurance because an employee becomes self-employed; loss of insurance because of a long-term disability; termination of insurance due to economic hardship of the employer; when the family faces extreme economic hardship; and a substantial reduction in lifetime medical benefits to an employee and dependents in an employer-sponsored plan.

We have made several changes to the list of exceptions to the minimum period without coverage under a group health plan. States may allow for exceptions to the minimum period without coverage under a group health plan when the child's coverage is involuntarily terminated due to employer termination of coverage for all employees and dependents. We have added an exception for cases when there is a change in employment that does not offer dependent coverage.

In addition, States may provide an exception when the child's family faces economic hardship. While States have flexibility to define this term, examples of economic hardship could be families who are facing unusual economic difficulties, such as the loss of a home to fire, or high out-of-pocket costs due to a family member's illness not being covered by insurance. Another example would be if a State is targeting its premium

assistance program to certain employers that provide only very limited health insurance coverage, a waiting period may not necessarily be required since the liklihood of substitution would be limited in those circumstances. Finally, we would consider an exception to the waiting period requirement if a State's proposal targeted low-wage employers in its premium assistance program, because substitution is much less likely when the coverage being subsidized is offered only by low-wage employers.

We anticipate that these reasonable exceptions will help facilitate States' ability to utilize premium assistance programs to enroll children in SCHIP.

Comment: One commenter noted that their State has had a Health Insurance Premium Payment (HIPP) program for Medicaid since July 1991. Under the HIPP program, the State pays the entire cost of the employee's share of the premium necessary to provide coverage to the Medicaid-eligible family members. Based on the State's experience with this program, they stated that they do not agree with our position that allowing States to assist families in the purchase of employer-related coverage will result in substitution of coverage. In fact, the commenter noted that as a condition of Medicaid eligibility, this State *requires* the family to maintain the insurance when it is cost-effective for the State to buy the coverage. This State argued that its policy supports the provision of premium assistance for employer

coverage and avoids substitution because the State maintains the coverage for the family.

The commenter believed that HCFA's position actually promotes substitution of coverage by making it harder for States to buy-in to employer health plans when they become available and, thus, depriving the State of the opportunity to buy coverage that is more cost effective to the State.

The commenter was particularly concerned about our proposal because they have a strong HIPP program. It appears to the commenter that, if the State is purchasing employer coverage under the HIPP program for a Medicaid-eligible child, at the time the child transitions to their separate SCHIP program, the child has health insurance through an employer (although the State was paying for it), would result in the imposition of a 6-month waiting period before the child could be eligible for SCHIP and before the State could continue buying-in to the employer coverage. The commenter wanted the flexibility to maintain employer-sponsored coverage for children when they transition between Medicaid and the separate SCHIP program.

Response: We understand the commenter's concerns and acknowledge that substitution policies raise complex issues for which there are no clear answers. We have revised our policy in a number of ways to allow States greater flexibility to design premium assistance programs and we will continue to work with

States as they evaluate how these programs are working and whether employer contributions are maintained. We note that in Medicaid, unlike SCHIP, having other health insurance coverage does not preclude eligibility for the program. With respect to the problem suggested by the commenter, we note that waiting periods do not apply when a child moves from a Medicaid program into a separate child health program because of an increase in family income, even if the Medicaid coverage was provided through an employer-based plan such as the case with the HIPP program. In this case the child would be considered to have been covered by Medicaid, rather than by group health insurance coverage.

Comment: One commenter noted that if a family has to be uninsured for six months before the children can receive coverage through premium assistance for a group health plan, the family may miss the employer's open enrollment period while it waits to have access to premium assisted coverage.

Response: We note that the minimum waiting period requirement applies to the SCHIP-eligible child, not the entire family. Thus, for example, a parent could elect self-only coverage and decline dependent coverage, and enroll immediately in the employer-sponsored health insurance. Then, once the six-month waiting period had been satisfied, the parent could enroll the child(ren) at the next open enrollment period and obtain SCHIP premium assistance. States may cover SCHIP-eligible

children in their regular SCHIP programs until such time as they can be enrolled in employer plans. Because §457.810 gives effect to an important congressional purpose related to SCHIP coverage, we are maintaining the minimum waiting period in this circumstance. However, we suggest that States adopt rules, under the scope of their regulatory authority consistent with HIPAA, to require a special enrollment opportunity in group health plans based on a SCHIP-eligible individual or family becoming eligible to enroll in the plan under a premium assistance program.

Comment: One commenter suggested that the general provisions of proposed §457.805, which say that "The State plan must include a description of reasonable procedures to ensure that coverage provided under the plan does not substitute for coverage under group health plans..." are sufficient and that proposed section §457.810 ("Premium assistance programs: Required protections against substitution.") should be deleted in order to allow States the flexibility to develop innovative approaches to utilizing employer-sponsored insurance coverage for SCHIP enrollees. The commenter indicated its belief that this approach would be in accord with Congress' intent that SCHIP programs be State-designed and State-operated, and that it would allow for the fact that private insurance markets and employer-sponsored health insurance patterns vary significantly from State to State. Proposed §457.810 would make it very difficult for the

implementation of employer-sponsored insurance under SCHIP.

Response: We understand the commenters concerns and have added some significant flexibility in this section of the final rule, as discussed above. We will work closely with States to develop premium assistance programs that fit their needs in the simplest and most operationally efficient way possible, while complying with the provisions of this final rule.

Comment: One commenter suggested that the language in §457.810(a)(1) is poorly drafted and appears to imply that children uninsured more than 12 months would not be provided SCHIP coverage.

Response: We agree and have revised the language in §457.810(a)(1) to clarify that a State, may not require a waiting period that exceeds 12 months.